



Request for Prior Authorization
SELECT ONCOLOGY AGENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA-approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B).

Provider specialty: _____

Patient information: Height: _____ (in) _____ (cm) Weight: _____ (lb) _____ (kg) BSA: _____

Diagnosis: _____

Medication requested: [] New [] Continuation

Table with 6 columns: Medication, Strength, Dosage Instructions, # of Cycles, Quantity, Days Supply

Previous treatment trials:

Table with 6 columns: Medication, Strength, Dosage Instructions, # of Cycles, Quantity, Days Supply

Attach copies of the following:

- [] Medical records (i.e., diagnostic evaluations and recent chart notes)
[] Original prescription
[] Recent related laboratory results

Please indicate setting in which medication is to be administered if medication requested is not an oral agent:

[] Home by home health [] Long-term care facility [] Other: _____

Has member or caregiver received proper training on storage, preparation, and administration technique if medication requested is not an oral agent? [] Yes [] No

Renewal requests: Has disease progressed? [] Yes [] No Date of last office visit: _____

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.